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No. 00-665

IN THE

Supreme Court of the United States

JOSE MONTEMAYOR, Commissioner of the Texas Department of Insurance, JOHN CORNYN, Attorney General of Texas,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICI CURIAE* TEXAS WATCH, RUBY CALAD AND WALTER PATRICK THORN IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST

Amici curiae are Texas Watch, Ruby Calad, and Walter Patrick Thorn.[1]

Texas Watch is an advocacy organization that serves to protect consumers by encouraging fair and professional treatment from insurance companies and HMOs. Both Texas Watch's constituency and the individual *amici* are directly affected by the issues raised in the petition for writ of certiorari pertaining to the scope of ERISA preemption of the Texas Health Care Liability Act's liability and independent-review provisions.

Ms. Calad and Mr. Thorn are individuals who have asserted under the 1997 Texas Health Care Liability Act that their HMOs denied them treatment on alleged "medical necessity" grounds. In Ruby Calad's case, Ms. Calad underwent a hysterectomy with rectal, bladder, and vaginal repair. Despite the very serious nature of this surgery, Ms. Calad's HMO authorized only one day for her hospital stay. Not qualifying under her HMO's "medical necessity" criteria for a continued stay, Ms. Calad suffered further pain when she was forced out of the hospital prematurely. Had her HMO deferred to and relied upon the advice and recommendation of Ms. Calad's treating physician, she would have remained in the hospital for additional time to recover from the traumatic surgery. Instead, Ms. Calad endured needless pain and suffering that resulted in her coming to the emergency room, just days after her premature discharge, with life-threatening complications.

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1. This *amici curiae* brief filed in support of the Petitioners was funded solely by the *amici* and authored entirely by counsel for the *amici*.

Mr. Thorn suffered severe injuries to his left hand in a car accident, requiring the amputation of his ring finger in the emergency room. Two physicians at the emergency room advised Mr. Thorn that another surgery would have to be performed promptly, within two to three days, in order to save the rest of his hand. Despite the recommendations of his primary-care physician and hand specialist, Mr. Thorn's HMO initially refused to authorize the surgery on "medical necessity" grounds, delaying the treatment for almost a week. As a result of this delay, Mr. Thorn has suffered greatly reduced mobility in, and use of, his hand.

Amici support the Petitioners, who seek review of the Fifth Circuit decision entered June 20, 2000, as well as the later decision denying rehearing, in the case styled *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, reported at 215 F.3d 526 (5th Cir. 2000) and 220 F.3d 641 (5th Cir. 2000), respectively. While the Fifth Circuit correctly held that ERISA does not preempt the liability and anti-retaliation provisions of the Texas Health Care Liability Act, these decisions wrongly concluded that the Act's provisions for independent review of HMO "medical necessity" decisions were preempted. Without extensive analysis, the Fifth Circuit simply concluded that the IRO regime, which serves to review an HMO's decisions on the "medical necessity" of treatment, "is squarely within the ambit of ERISA's preemptive reach." 215 F.3d at 537.

But the Fifth Circuit failed to properly apply this Court's decision in *Pegram v. Herdrich*, which held that HMO physicians making medical-necessity decisions are *not* making either fiduciary or administrative decisions, but are engaging in "mixed decisions" identical to those made by doctors in millions of other contexts — decisions that ERISA

does not preempt. Because of the way that HMOs define what they will and will not "cover," essentially entering the realm of medical-necessity decision-making, HMOs are engaging in the practice of medicine historically regulated by the states, a result neither intended nor supported by the legislative history of the Federal HMO Act.

For these reasons, *amici* support the petition filed by Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas. Given the importance of the IRO provisions to consumers, *amici* believe they can assist the Court in addressing whether ERISA preempts those provisions, and urge this Court to grant a writ of certiorari in this case.

SUMMARY OF ARGUMENT

Texas' petition for writ of certiorari thoroughly details the split in circuit-court authority, analyzes ERISA's savings clause, and presents related reasons for this Court to grant the petition for writ of certiorari. *Amici* agree with all the points made, and write separately only to emphasize two further reasons for granting the writ: First, the Court's opinion in *Pegram v. Herdrich* signals broad acceptance of the idea that "mixed" eligibility and treatment decisions within an HMO structure implicate only state-law concerns and not ones covered by ERISA[2] — an idea that ought logically result in a holding that Texas' independent-review-organization ("IRO") legislation is also properly the province of state rather than federal law. Second, *Pegram*'s reliance, for part of its analysis, on the Health Maintenance

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2. Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001, *et seq.*

Organization Act of 1973[3] — a statute predating ERISA by a year — makes useful an examination of the legislative history of that Act, for considering it in tandem with ERISA's purpose and intended scope yields further support for the validity of Texas' IRO legislation.

ARGUMENT

1. *Pegram v. Herdrich*: Congress did not intend for ERISA to preempt health-care issues, nor to set up a federalized system of treating medical-necessity determinations, when made by an HMO, as fiduciary in nature.

Earlier this year the Court held that mixed treatment and eligibility decisions made by an HMO, acting through its physicians, are not fiduciary acts under ERISA. *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). Asked to hold that an HMO physician's delaying needed medical care to save money for the HMO and increase the physician's compensation breaches ERISA's fiduciary-duty provisions, the Court unanimously said no. Though *Pegram* did not involve whether ERISA preempts state legislation creating an independent body to review concurrent and prospective medical treatment and to opine on its necessity, the Court's reasoning is nonetheless instructive, and controlling here.

Pegram is but the latest, in fact, of a line of cases in which this Court has noted that ERISA's preemptive reach was not so broad as earlier thought; beginning in 1995, the Court handed down a trilogy of cases reining in the notion that ERISA preempts any law that could be said to in any

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3. 42 U.S.C.A. §§ 300e, *et seq.*

way "relate to" an employee-benefit plan. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 117 S. Ct. 1747 (1997). Conversely, according to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. See 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan"). [*Pegram*, 120 S. Ct. at 2158.]

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.*

And, importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S.*

> *Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response? [*Id.* at 2153-54.]

The Court then concluded that Herdrich's complaint raised "just such *mixed* eligibility and treatment decisions," giving as examples

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. [*Id.* at 2155.]

Another way to phrase these types of decisions is, of course, that they are ones of "medical necessity."

The next section of the *Pegram* decision signaled the end of ERISA preemption of mixed eligibility decisions — a category that naturally subsumes medical-necessity determinations — with Justice Souter opining that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress

would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* Because those types of decisions are not fiduciary ones under ERISA, the Court's conclusion effectively ends ERISA preemption of state-law claims focused on an HMO's medical-necessity decisions, since they are by definition mixed eligibility ones.[4]

Though a finding of no fiduciary status with regard to medical-necessity decisions is not necessarily tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions (a question the Court has not faced until now), the holding and reasoning in *Pegram*, especially when coupled with this Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result.[5]

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4. *Pegram* would also seem to implicitly disapprove the Fifth Circuit's earlier decision in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), which held just such "mixed" decisions to be preempted. On petition for rehearing in the instant case, the Fifth Circuit rejected that view. 220 F.3d 641, 643-44 (5th Cir. 2000) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise." (Footnotes omitted.)).

5. Too, just one week after deciding *Pegram*, this Court denied an HMO's petition for writ of certiorari in *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 2000 U.S. Lexis 4177, 68 U.S.L.W. 3773 (June 19, 2000). In *Bauman*, the Third Circuit held that ERISA did not completely preempt the plaintiffs' claims that their HMO's failure to approve an in-home pediatric nurse visit led to their newborn daughter's death from an undiagnosed and untreated strep infection. ("[I]t is the HMO's

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Here, the Texas IRO legislation does nothing more than regulate the *quality* of medical care — the practice of medicine — by providing a mechanism for plan participants to obtain a medical "second opinion" about whether a particular course of treatment is indeed medically necessary. Because it implicates, at most, a mixed treatment issue, that legislation falls squarely within the ambit that Congress — and this Court — recognize as being reserved to the states.

The *Pegram* Court made it clear that mixed decisions are nothing more than medical-treatment decisions made "millions of times every day"[6] in other contexts, and that the decisions in those contexts are subject to state law. The most plausible conclusion to draw from *Pegram* is that even when an HMO arrogates to itself the "medical necessity" second-guessing function by the way that it writes its coverage agreement, the medical-necessity analysis by the HMO's medical director would not trigger preemption — and state law continues its vital role in regulating the HMO's health-care treatment decisions.

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essentially medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. . . . Accordingly, the claim fits squarely within a class of claims that we identified in *Dukes* as involving the quality of care [and thus not preempted].") 193 F.3d at 163. Apparently rejecting the HMO's argument that the Baumans sought to recover for a denial of benefits — normally a preempted claim — this Court's denial of the petition for writ of certiorari shows that *Pegram*'s holding and reasoning are not limited to the narrow question of fiduciary status for a malfeasant HMO.

6. 120 S. Ct. at 2156.

In short, given the development in caselaw from *Travelers* through *Pegram*, and the evolving refinements to preemption issues that this Court's decisions represent, the Fifth Circuit erred in holding the IRO portions of the Texas Health Care Liability Act preempted. And because some thirty-four states and the District of Columbia have enacted similar independent-review procedures, this is an issue of national importance.[7]

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7. 2000 Alaska Sess. Laws 99, ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999), CAL. [INS.] CODE § 10169 (West Supp. 2000), COLO. REV. STAT. § 10-16-113.5 (West 1999), CONN. GEN. STAT. § 38a-478n (West Supp. 2000), DEL. CODE ANN. tit. 16, § 9119 (2000), D.C. CODE § 32-571.7 (Lexis Supp. 2000), 2000 Fla. Laws ch. 00-256 (West), GA. CODE ANN.§ 33-20A-32 (2000), 2000 Haw. Sess. Laws 250, 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000), IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000), IOWA CODE ANN. § 514J (West 2000), KAN. STAT. ANN. § 40-22a13 (Supp. 1999), 2000 Kentucky Laws Reg. Sess. 262 (West), LA. REV. STAT. ANN. § 22:3081 (2000), 2000 Me. Legis. Serv. 742 (West), MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999), 2000 Mich. Legis. Serv. 251 (West), MINN. STAT. ANN. § 62Q.73 (West Supp. 2000), MO. REV. STAT. § 376.1385 (1997), MONT. CODE ANN. § 33-37-102 (1999), N.H. REV. STAT. ANN. 420-J:5 (2000), N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000), N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000), N.Y. [INS.] LAW § 4904 (McKinney 1999), N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998), OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000), OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999), 40 PA. CONS. STAT. § 991.2162 (1998), R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000), 2000 S.C. Acts 380, TENN. CODE ANN. § 56-32-227 (West 1999), UTAH CODE ANN. § 31A-22-629 (2000), VT. STAT. ANN. tit. 8, § 4089f (1998), VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000), 2000 Wash. Legis. Serv. 5 (West), 2000 Wisc. Legis. Serv. 155 (West).

2. The background and purpose of the 1973 Federal HMO Act show that Congress did not intend to remove medical-necessity issues from health-care providers — or from the states.

In addition to the aspects of *Pegram* discussed above, the Court also made explicit the usefulness of considering Congress's enactment of the Health Maintenance Organization Act of 1973 just one year before it enacted ERISA: in the Court's view, Congress could hardly have meant to encourage the formation of HMOs only to stifle them a year later by (if Herdrich's interpretation were accepted) including a fiduciary-duty standard in ERISA whose enforcement would entail "nothing less than elimination of the for-profit HMO." *Pegram*, 120 S. Ct. at 2156.[8]

While debate could be had on this latter conclusion (a debate not called for here), the pertinent point for the instant case is this: when considering whether Congress meant for ERISA to preempt state-law quality-of-care/medical-necessity regulation of HMOs, such as Texas' IRO provisions, examining the federal HMO Act's legislative history is just as useful as examining that of ERISA itself. To *amici*'s knowledge, no case to date has done so, thus presenting the Court with an opportunity to delve more deeply into just how the two acts should be interpreted in tandem for preemption purposes.

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8. The *Pegram* Court noted that "for over 27 years the Congress of the United States has promoted the formation of HMO practices" and that federal courts would be "acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm." 120 S. Ct. at 2156-57.

Analysis of the federal HMO Act — principally its 1973 legislative history and that of later specific amendments — shows that Congress intended the *states* to regulate HMO quality, including medical-necessity determinations, and never contemplated that HMOs would be able to arrogate to themselves the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to create, or even to show cognizance of, a process whereby *health plans* take from treating doctors, and the states, the determination of what care is appropriate, i.e., medically necessary.

Several portions of the legislative history support *amici*'s view:

First, though Congress explored implementing a comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance,[9] it ultimately decided *not* to create such a commission, instead leaving quality-of-care regulation to the states. Indeed, the only preemption provisions that were enacted addressed states' barriers to the formation of HMOs, such as those prohibiting prepaid plans.[10]

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9. Much of the 1973 Senate Report dealt with the proposed commission, but the actual HMO Act dropped it altogether when finally enacted. *See* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033.

10. *Id.* at 3057 ("Section 1243 in this bill preempts restrictive state laws which impair the formation or operation of health maintenance organizations and health service organizations. Several

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But even when Congress was seriously contemplating regulating and overseeing HMO quality of care at the federal level, it recognized that some oversight and control by the states was appropriate. For example, in a separate section of the Senate Report, entitled "State Standards," the Committee on Labor and Public Welfare discussed the proposed Commission on Quality Health Care Assurance, making clear that local (i.e., state) concerns would govern health-care standards applicable to HMOs:

> [The Committee] is of the opinion that *the states*, through a designated state agency, *should be given the opportunity to develop health care standards* so that local and other variations can be taken into account though the Commission would have to assure itself that such standards would at least be as effective and rigorous as those the Commission itself would otherwise institute. The Commission is aware, for instance, that disease patterns and treatment methodologies do differ, and appropriately so, from state to state.[11]

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states have laws which restrict group practice, the corporate practice of medicine, and impose other conditions for approval. Under this section, providers of health care receiving quality health care initiative awards under title III are given the authority to function regardless of restrictive state legislation. As of May 1971, twenty-two states continued to have laws prohibiting prepaid group practice."). *See* 42 U.S.C.A. § 300e-10(a).

11. *Id.* at 3077 (emphasis added).

And in the following paragraph, the Senate Committee stated:

> An added factor in this Committee's decision to *encourage states* to *develop their own standards* is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.[12]

As the HMO Act was initially conceived, the Committee thus envisioned that each state should be given the opportunity to enforce its own promulgated HMO-quality standards, and nothing in the subsequent Conference Report or floor debate negates this clear congressional intent that (a) treating medical professionals, not HMOs, would determine "medical necessity"; and (b) the states would be responsible for administering HMO quality standards for health care, including "medical necessity." And since Congress ultimately rejected establishing a federal commission that would have, to some extent, usurped state control, its intent is clear: quality-of-care issues — including those of medical necessity — were best left *entirely* to state control and regulation.

Elsewhere in the Senate Reports for the 1973 Act, it is apparent that the Committee on Labor and Public Welfare

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12. *Id.* (emphasis added).

considered that the HMO structure would actually *remove* any financial incentives from the practice of medicine at the physician level, thereby — again — leaving medical-necessity determinations to the actual health-care providers and also, by logical extension, to the states, which were implicitly (in the Act as enacted) given sole authority to regulate the field of health care:

> The medical group approach also provides opportunity for a restructuring of financial incentives. A health professional's income is not related directly to the number of services he provides, thereby removing a major incentive for over-utilization of services. In addition, it allows the *health professionals* to make judgments *based on medical necessity alone*.[13]

This language has never received substantial attention, especially in analyzing the interplay between the Federal HMO Act and ERISA, passed the very next year. Though *Pegram* recognized the importance of the two acts adopted one year apart, that opinion did not explore the actual legislative history. When that is done, it becomes inconceivable that with the federal HMO Act Congress (a) meant to facilitate the removal of any financial incentives affecting medical-necessity determinations and to encourage "health professionals" and not HMOs to "make judgments based upon medical necessity alone," but (b) with ERISA, the very next year, it somehow intended to bestow on employee benefit plans, or on HMO providers contracting with ERISA plans, the ability to circumvent the prior year's intent that "*health professionals* [would make] judgments

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13. *Id.* at 3047 (emphasis added).

based on *medical necessity alone*." This conclusion is bolstered considerably by Congress's decision to leave all quality-of-care issues — including ones of medical necessity — to state control.

Also noteworthy is that proposed section 1311(A) of the Act would have permitted a state agency or court to assert its jurisdiction under state law over any "health issue" not affected by standards or criteria promulgated under § 1302 of the Act.[14] The absence of any manifested intent even here to preempt state-law quality-of-care standards, and the eventual adoption of an Act that allows total state-law enforcement of health-care standards, effectively negates any argument that the federal HMO Act began an attempt by Congress to allow federal preemption under the guise of either the HMO Act or ERISA, one year later, of state-law medical-necessity regulation.

And in the 1976 legislative session, just two years after enacting ERISA, Congress considered but rejected a federal-court remedy for enrollees of an HMO who were given assurances by an HMO, directly or indirectly, about basic and supplemental health services.[15] The conference substitute noted that rejecting the Senate's proposed federal remedy "[did] not change any existing right of individuals to bring suit in state courts."[16] This legislative history indicates that

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14. Section 1302 set forth the proposed functions of the (ultimately jettisoned) Commission.

15. H.R. CONF. REP. NO. 94-1513 (1976), *reprinted in* 1976 U.S.C.C.A.N. 4355, 4366.

16. *Id.*

Congress did not intend to preempt even state-law fraud claims against HMOs, an intent evinced a mere two years after it enacted ERISA.

At bottom, it makes no sense to suppose that just one year after adopting the federal HMO Act — which deliberately left HMO quality-of-care regulation to the states — Congress intended through ERISA to supplant the states' ability to regulate the quality of medical care that HMOs provide. And nothing in ERISA's later development indicates any congressional intent, at any time, to override the clear intent contained in the HMO Act: that the states would be the ones to adopt and enforce HMO medical-care/health-care regulation.

Viewed in this light, Texas' IRO provisions simply fulfill what Congress envisioned when it decided to encourage the limited formation of HMOs some 27 years ago. What Congress gave the states with one hand — the ability to settle on appropriate quality-of-care standards — it did not take away with the other. As Justice Souter signaled in *Pegram*, it is wholly appropriate to consider the HMO Act when analyzing ERISA's preemptive effects on state laws that seek to establish the level of quality medical care that an HMO must provide. It would add considerably to the extant body of ERISA caselaw if this Court were to grant the petition for writ of certiorari and expound on the interplay between the two acts, especially given the large number of states that have enacted laws similar to the Texas IRO legislation.

CONCLUSION

This case presents an important issue: Can a state lawfully adopt legislation ensuring that its citizens get medically necessary care from an HMO operating within that state's borders? Based on this Court's holding in *Pegram* and on the legislative history of the 1973 HMO Act, the answer is plainly yes. *Amici* respectfully urge this Court to grant the petition for writ of certiorari so that it can fully consider whether the Fifth Circuit erred in its contrary answer.

Respectfully submitted,

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